

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (Amendment)

5 907 KAR 3:005. Coverage of physicians' services.

6 RELATES TO: KRS 205.520, 205.560, 42 C.F.R. 415.152, 415.174, 415.184,
7 440.50, 447.26, 45 C.F.R. 160, 164, 42 U.S.C. 1320 - 1320d-8, 1396a(a)(19), (30)

8 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1)

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
10 Services, Department for Medicaid Services, has responsibility to administer the Medi-
11 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to
12 comply with any requirement that may be imposed or opportunity presented by federal
13 law to qualify for federal Medicaid funds. This administrative regulation establishes the
14 Medicaid Program coverage provisions and requirements relating to physicians' ser-
15 vices.

16 Section 1. Definitions. (1) "Advanced practice registered nurse" or "APRN" is defined
17 by KRS 314.011(7).

18 (2) "Behavioral health practitioner under supervision" means an individual who is:

19 (a) A licensed psychological associate;

20 (b) A licensed professional counselor associate;

1 (c) A certified social worker;

2 (d) A marriage and family therapy associate;

3 (e) A licensed professional art therapist associate;

4 (f) A licensed assistant behavior analyst;

5 (g) A physician assistant; or

6 (h) A certified alcohol and drug counselor.

7 (3) "Common practice" means an arrangement through which a physician assistant
8 administers health care services under the supervision of a physician via a supervisory
9 relationship that has been approved by the Kentucky Board of Medical Licensure.

10 (4)~~(3)~~ "CPT code" means a code used for reporting procedures and services per-
11 formed by medical practitioners and published annually by the American Medical Asso-
12 ciation in Current Procedural Terminology.

13 (5)~~(4)~~ "Department" means the Department for Medicaid Services or its designee.

14 (6)~~(5)~~ "Designated controlled substance provider" means the provider designated
15 as a lock-in recipient's controlled substance prescriber:

16 (a) Pursuant to 907 KAR 1:677, if the recipient is not an enrollee; or

17 (b) As established by the managed care organization in which the lock-in recipient is
18 enrolled, if the lock-in recipient is an enrollee.

19 (7)~~(6)~~ "Designated primary care provider" means the provider designated as a lock-
20 in recipient's primary care provider:

21 (a) Pursuant to 907 KAR 1:677, if the recipient is not an enrollee; or

22 (b) As established by the managed care organization in which the lock-in recipient is
23 enrolled, if the lock-in recipient is an enrollee.

1 (8)~~[(7)]~~ "Direct physician contact" means that the billing physician is physically pre-
2 sent with and evaluates, examines, treats, or diagnoses the recipient.

3 (9)~~[(8)]~~ "Early and periodic screening and diagnosis and treatment" or "EPSDT" is
4 defined by 42 C.F.R. 440.40(b).

5 (10)~~[(9)]~~ "Emergency care" means:

6 (a) Covered inpatient or outpatient services furnished by a qualified provider that are
7 needed to evaluate or stabilize an emergency medical condition that is found to exist
8 using the prudent layperson standard; or

9 (b) Emergency ambulance transport.

10 (11)~~[(10)]~~ "Enrollee" means a recipient who is enrolled with a managed care organi-
11 zation.

12 (12)~~[(11)]~~ "Federal financial participation" is defined by 42 C.F.R. 400.203.

13 (13)~~[(12)]~~ "Global period" means the period of time in which related preoperative, in-
14 traoperative, and postoperative services and follow-up care for a surgical procedure are
15 customarily provided.

16 (14)~~[(13)]~~ "Graduate medical education program" or "GME Program" means:

17 (a) A residency program approved by:

18 1. The Accreditation Council for Graduate Medical Education of the American Medi-
19 cal Association;

20 2. The Committee on Hospitals of the Bureau of Professional Education of the Amer-
21 ican Osteopathic Association;

22 3. The Commission on Dental Accreditation of the American Dental Association; or

23 4. The Council on Podiatric Medicine Education of the American Podiatric Medical

1 Association; or

2 (b) An approved medical residency program as defined in 42 C.F.R. 413.75(b).

3 (15)~~[(44)]~~ "Incidental" means that a medical procedure:

4 (a) Is performed at the same time as a primary procedure; and

5 (b)1. Requires little additional resources; or

6 2. Is clinically integral to the performance of the primary procedure.

7 (16)~~[(45)]~~ "Integral" means that a medical procedure represents a component of a
8 more complex procedure performed at the same time.

9 (17)~~[(46)]~~ "Lock-in recipient" means:

10 (a) A recipient enrolled in the lock-in program in accordance with 907 KAR 1:677; or

11 (b) An enrollee enrolled in a managed care organization's lock-in program pursuant
12 to 907 KAR 17:020, Section 8.

13 (18)~~[(47)]~~ "Locum tenens APRN" means an APRN:

14 (a) Who temporarily assumes responsibility for the professional practice of a physi-
15 cian participating in the Kentucky Medicaid Program; and

16 (b) Whose services are billed under the APRN's provider number.

17 (19)~~[(48)]~~ "Locum tenens physician" means a substitute physician:

18 (a) Who temporarily assumes responsibility for the professional practice of a physi-
19 cian participating in the Kentucky Medicaid Program; and

20 (b) Whose services are paid under the participating physician's provider number.

21 (20)~~[(49)]~~ "Managed care organization" means an entity for which the Department for
22 Medicaid Services has contracted to serve as a managed care organization as defined
23 in 42 C.F.R. 438.2.

1 (21)~~[(20)]~~ "Medicaid basis" means a scenario in which:

2 (a) A provider provides a service to a recipient as a Medicaid-participating provider in
3 accordance with:

4 1. 907 KAR 1:671; and

5 2. 907 KAR 1:672;

6 (b) The Medicaid Program is the payer for the service; and

7 (c) The recipient is not liable for payment to the provider for the service other than
8 any cost sharing obligation owed by the recipient to the provider.

9 (22)~~[(21)]~~ "Medical necessity" or "medically necessary" means that a covered benefit
10 is determined to be needed in accordance with 907 KAR 3:130.

11 (23)~~[(22)]~~ "Medical resident" means:

12 (a) An individual who participates in an approved graduate medical education (GME)
13 program in medicine or osteopathy; or

14 (b) A physician who is not in an approved GME program, but who is authorized to
15 practice only in a hospital, including:

16 1. An individual with a:

17 a. Temporary license;

18 b. Resident training license; or

19 c. Restricted license; or

20 2. An unlicensed graduate of a foreign medical school.

21 (24)~~[(23)]~~ "Mutually exclusive" means that two (2) procedures:

22 (a) Are not reasonably performed in conjunction with one another during the same
23 patient encounter on the same date of service;

- 1 (b) Represent two (2) methods of performing the same procedure;
- 2 (c) Represent medically impossible or improbable use of CPT codes; or
- 3 (d) Are described in Current Procedural Terminology as inappropriate coding of pro-
- 4 cedure combinations.

5 (25)~~(24)~~ "Non-Medicaid basis" means a scenario in which:

- 6 (a) A provider provides a service to a recipient;
- 7 (b) The Medicaid Program is not the payer for the service; and
- 8 (c) The recipient is liable for payment to the provider for the service.

9 (26)~~(25)~~ "Other licensed medical professional" means a health care provider:

- 10 (a) Other than a physician, physician assistant, advanced practice registered nurse,
- 11 certified registered nurse anesthetist, nurse midwife, or registered nurse; and
- 12 (b) Who has been approved to practice a medical specialty by the appropriate licen-
- 13 sure board.

14 (27)~~(26)~~ "Other provider preventable condition" is defined in 42 C.F.R. 447.26(b).

15 (28)~~(27)~~ "Physician assistant" is defined in KRS 311.840(3).

16 (29)~~(28)~~ "Physician injectable drug" means an injectable, infused, or inhaled drug or

17 biological that:

- 18 (a) Is not typically self-administered;
- 19 (b) Is not excluded as a noncovered immunization or vaccine;
- 20 (c) Requires special handling, storage, shipping, dosing, or administration; and
- 21 (d) Is a rebatable drug.

22 (30)~~(29)~~ "Podiatrist" is defined by KRS 205.510(12).

23 (31)~~(30)~~ "Rebatable drug" means a drug for which the drug's manufacturer has en-

tered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

(32)~~[(31)]~~ "Recipient" is defined by KRS 205.8451(9).

(33)~~[(32)]~~ "Screening" means the evaluation of a recipient by a physician to determine:

(a) If a disease or medical condition is present; and

(b) If further evaluation, diagnostic testing, or treatment is needed.

(34)~~[(33)]~~ "Supervising physician" is defined in KRS 311.840(4).

(35)~~[(34)]~~ "Supervision" is defined in KRS 311.840(6).

(36)~~[(35)]~~ "Timely filing" means receipt of a Medicaid claim by the department:

(a) Within twelve (12) months of the date the service was provided;

(b) Within twelve (12) months of the date retroactive eligibility was established; or

(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.

(37)~~[(36)]~~ "Unlisted procedure or service" means a procedure or service:

(a) For which there is not a specific CPT code; and

(b) Which is billed using a CPT code designated for reporting unlisted procedures or services.

Section 2. Conditions of Participation. (1)(a) A participating physician shall:

1. Be licensed as a physician in the state in which the medical practice is located;

2. Comply with the:

a. Terms and conditions established in 907 KAR 1:005, 907 KAR 1:671, and 907 KAR 1:672;

b. Requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164;

3. Have the freedom to choose whether to provide services to a recipient; and

4. Notify the recipient referenced in paragraph (b) of this subsection of the provider's decision to accept or not accept the recipient on a Medicaid basis prior to providing any service to the recipient.

(b) A provider may provide a service to a recipient on a non-Medicaid basis:

1. If the recipient agrees to receive the service on a non-Medicaid basis before the service begins; and

~~2. [Whether or not] The[:~~

~~a. Provider is a Medicaid-participating provider; or~~

~~b.] Service is not a Medicaid-covered service.~~

(2) If a provider agrees to provide services to a recipient, the provider:

(a) Shall bill the department rather than the recipient for a covered service;

(b) May bill the recipient for a service not covered by Medicaid if the physician informed the recipient of noncoverage prior to providing the service; and

(c) Shall not bill the recipient for a service that is denied by the department on the basis of:

1. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;

2. Incorrect billing procedures, including incorrect bundling of services;

3. Failure to obtain prior authorization for the service; or

4. Failure to meet timely filing requirements.

1 (3)(a) If a provider receives any duplicate payment or overpayment from the depart-
2 ment, regardless of reason, the provider shall return the payment to the department.

3 (b) Failure to return a payment to the department in accordance with paragraph (a) of
4 this subsection may be:

5 1. Interpreted to be fraud or abuse; and

6 2. Prosecuted in accordance with applicable federal or state law.

7 (4)(a) A provider shall maintain a current health record for each recipient.

8 (b)1. A health record shall document each service provided to the recipient including
9 the date of the service and the signature of the individual who provided the service.

10 2. The individual who provided the service shall date and sign the health record on
11 the date that the individual provided the service.

12 (5)(a) Except as established in paragraph (b) of this subsection, a provider shall
13 maintain a health record regarding a recipient for at least five (5) years from the date of
14 the service or until any audit dispute or issue is resolved beyond five (5) years.

15 (b) If the secretary of the United States Department of Health and Human Services
16 requires a longer document retention period than the period referenced in paragraph (a)
17 of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secre-
18 tary shall be the required period.

19 (6) A provider shall comply with 45 C.F.R. Part 164.

20 Section 3. Covered Services. (1) To be covered by the department, a service shall
21 be:

22 (a) Medically necessary;

23 (b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;

(c) Except as provided in subsection (2) of this section, furnished to a recipient through direct physician contact; and

(d) Eligible for reimbursement as a physician service.

(2) Direct physician contact between the billing physician and recipient shall not be required for:

(a) A service provided by a:

1. Medical resident if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.174 and 415.184;

2. Locum tenens physician who provides direct physician contact;

3. Physician assistant in accordance with Section 7 of this administrative regulation;

or

4. Locum tenens APRN who provides direct APRN contact;

(b) A radiology service, imaging service, pathology service, ultrasound study, echographic study, electrocardiogram, electromyogram, electroencephalogram, vascular study, or other service that is usually and customarily performed without direct physician contact;

(c) The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;

(d) A sleep disorder service; or

(e) A telehealth consultation provided in accordance with 907 KAR 3:170.

(3) A service provided by an other licensed medical professional shall be covered if the other licensed medical professional is:

(a) Employed by the supervising physician; and

1 (b) Licensed in the state of practice.

2 (4) A sleep disorder service shall be covered if performed in:

3 (a) A hospital;

4 (b) A sleep laboratory if the sleep laboratory has documentation demonstrating that it
5 complies with criteria approved by the:

6 1. American Sleep Disorders Association; or

7 2. American Academy of Sleep Medicine; or

8 (c) An independent diagnostic testing facility that:

9 1. Is supervised by a physician trained in analyzing and interpreting sleep disorder
10 recordings; and

11 2. Has documentation demonstrating that it complies with criteria approved by the:

12 a. American Sleep Disorders Association; or

13 b. American Academy of Sleep Medicine.

14 Section 4. Service Limitations. (1) A covered service provided to a lock-in recipient
15 shall be limited to a service provided by the lock-in recipient's designated primary care
16 provider or designated controlled substance prescriber unless:

17 (a) The service represents emergency care; or

18 (b) The lock-in recipient has been referred to the provider by the lock-in recipient's
19 designated primary care provider.

20 (2) An EPSDT screening service shall be covered in accordance with 907 KAR
21 11:034.

22 (3) A laboratory procedure performed in a physician's office shall be limited to a pro-
23 cedure for which the physician has been certified in accordance with 42 C.F.R. Part

1 493.

2 (4) Except for the following, a drug administered in a physician's office shall not be
3 covered as a separate reimbursable service through the physicians' program:

4 (a) Rho (D) immune globulin injection;

5 (b) An injectable antineoplastic drug;

6 (c) Medroxyprogesterone acetate for contraceptive use, 150 mg;

7 (d) Penicillin G benzathine injection;

8 (e) Ceftriaxone sodium injection;

9 (f) Intravenous immune globulin injection;

10 (g) Sodium hyaluronate or hylan G-F for intra-articular injection;

11 (h) An intrauterine contraceptive device;

12 (i) An implantable contraceptive device;

13 (j) Long acting injectable risperidone; or

14 (k) An injectable, infused, or inhaled drug or biological that:

15 1. Is not typically self-administered;

16 2. Is not excluded as a noncovered immunization or vaccine; and

17 3. Requires special handling, storage, shipping, dosing, or administration.

18 (5) A service allowed in accordance with 42 C.F.R. 441, Subpart E or Subpart F,
19 shall be covered within the scope and limitations of 42 C.F.R. 441, Subpart E and Sub-
20 part F.

21 (6)(a) Except as provided in paragraph (b) of this subsection, coverage for a service
22 designated as a psychiatry service CPT code and provided by a physician shall be lim-
23 ited to four (4) services, per physician, per recipient, per twelve (12) months.

1 (b) Coverage for a service designated as a psychiatry service CPT code that is pro-
2 vided by a board certified or board eligible psychiatrist or by an advanced practice regis-
3 tered nurse with a specialty in psychiatry shall not be subject to the limits established in
4 paragraph (a) of this subsection.

5 (c) Coverage for an evaluation and management service shall be limited to one (1)
6 per physician, per recipient, per date of service.

7 (d) Coverage for a fetal diagnostic ultrasound procedure shall be limited to two (2)
8 per nine (9) month period per recipient unless the diagnosis code justifies the medical
9 necessity of an additional procedure.

10 (7) An anesthesia service shall be covered if:

11 (a) Administered by:

12 1. An anesthesiologist who remains in attendance throughout the procedure; or

13 2. An individual who:

14 a. Is licensed in Kentucky to practice anesthesia;

15 b. Is licensed in Kentucky within his or her scope of practice; and

16 c. Remains in attendance throughout the procedure;

17 (b) Medically necessary; and

18 (c) Not provided as part of an all-inclusive CPT code.

19 (8) The following shall not be covered:

20 (a) An acupuncture service;

21 (b) An autopsy;

22 (c) A cast or splint application in excess of the limits established in 907 KAR 3:010;

23 (d) Except for therapeutic bandage lenses, contact lenses;

- 1 (e) A hysterectomy performed for the purpose of sterilization;
- 2 (f) Lasik surgery;
- 3 (g) Paternity testing;
- 4 (h) A procedure performed for cosmetic purposes only;
- 5 (i) A procedure performed to promote or improve fertility;
- 6 (j) Radial keratotomy;
- 7 (k) A thermogram;
- 8 (l) An experimental service which is not in accordance with current standards of med-
9 ical practice;
- 10 (m) A service which does not meet the requirements established in Section 3(1) of
11 this administrative regulation;
- 12 (n) Medical direction of an anesthesia service; or
- 13 (o) Medical assistance for an other provider preventable condition in accordance with
14 907 KAR 14:005.

15 Section 5. Prior Authorization Requirements for Recipients Who are Not Enrolled
16 with a Managed Care Organization. (1) The following procedures for a recipient who is
17 not enrolled with a managed care organization shall require prior authorization by the
18 department:

- 19 (a) Magnetic resonance imaging;
- 20 (b) Magnetic resonance angiogram;
- 21 (c) Magnetic resonance spectroscopy;
- 22 (d) Positron emission tomography;
- 23 (e) Cineradiography or videoradiography;

- (f) Xeroradiography;
- (g) Ultrasound subsequent to second obstetric ultrasound;
- (h) Myocardial imaging;
- (i) Cardiac blood pool imaging;
- (j) Radiopharmaceutical procedures;
- (k) Gastric restrictive surgery or gastric bypass surgery;
- (l) A procedure that is commonly performed for cosmetic purposes;
- (m) A surgical procedure that requires completion of a federal consent form; or
- (n) A covered unlisted procedure or service.

(2)(a) Prior authorization by the department shall not be a guarantee of recipient eligibility.

(b) Eligibility verification shall be the responsibility of the provider.

(3) The prior authorization requirements established in subsection (1) of this section shall not apply to:

(a) An emergency service;

(b) A radiology procedure if the recipient has a cancer or transplant diagnosis code;

or

(c) A service provided to a recipient in an observation bed.

(4) A referring physician, a physician who wishes to provide a given service, a podiatrist, a chiropractor, or an advanced practice registered nurse:

(a) May request prior authorization from the department; and

(b) If requesting prior authorization, shall request prior authorization by:

1. Mailing or faxing:

1 a. A written request to the department with ~~[sufficient]~~ information sufficient to
2 demonstrate that the service meets the requirements established in Section 3(1) of this
3 administrative regulation; and

4 b. If applicable, any required federal consent forms; or

5 2. Submitting a request via the department's web-based portal with information suffi-
6 cient to demonstrate that the service meets the requirements established in Section
7 3(1) of this administrative regulation.

8 Section 6. Therapy Service Limits. (1) Speech-language pathology services shall be
9 limited to twenty (20) service visits per recipient per calendar year, except as estab-
10 lished in subsection (4) of this section.

11 (2) Physical therapy services shall be limited to twenty (20) service visits per recipient
12 per calendar year, except as established in subsection (4) of this section.

13 (3) Occupational therapy services shall be limited to twenty (20) service visits per re-
14 cipient per calendar year, except as established in subsection (4) of this section.

15 (4) A service in excess of the limits established in subsection (1), (2), or (3) of this
16 section shall be approved if the additional service is determined to be medically neces-
17 sary by:

18 (a) The department, if the recipient is not enrolled with a managed care organization;
19 or

20 (b) Managed care organization in which the enrollee is enrolled, if the recipient is an
21 enrollee.

22 (5) Prior authorization by the department shall be required for each service visit that
23 exceeds the limit established in subsection (1), (2), or (3) of this section for a recipient

1 who is not enrolled with a managed care organization.

2 Section 7. Physician Assistant Services. (1) Except for a service limitation specified
3 in subsections (2) or (3) of this section, a service provided by a physician assistant in
4 common practice with a Medicaid-enrolled physician shall be covered if:

5 (a) The service meets the requirements established in Section 3(1) of this adminis-
6 trative regulation;

7 (b) The service is within the legal scope of certification of the physician assistant;

8 (c) The service is billed under the physician's individual provider number with the
9 physician assistant's number included; and

10 (d) The physician assistant complies with:

11 1. KRS 311.840 to 311.862; and

12 2. Section 2(1)(b) of this administrative regulation.

13 (2) A same service performed by a physician assistant and a physician on the same
14 day within a common practice shall be considered as one (1) covered service.

15 (3) The following physician assistant services shall not be covered:

16 (a) A physician noncovered service specified in Section 4(8) of this administrative
17 regulation;

18 (b) An anesthesia service;

19 (c) An obstetrical delivery service; or

20 (d) A service provided in assistance of surgery.

21 Section 8. Behavioral Health Services Covered Pursuant to 907 KAR 15:010. The
22 requirements and provisions established in 907 KAR 15:010 for a service covered pur-
23 suant to 907 KAR 15:010 shall apply if the service is provided by:

1 (1) A physician who is the billing provider;

2 (2) An APRN who works for a physician who is the billing provider; or

3 (3) A behavioral health practitioner under supervision who works for a physician who
4 is the billing provider.

5 Section 9. No Duplication of Service. (1) The department shall not reimburse for a
6 service provided to a recipient by more than one (1) provider of any program in which
7 the service is covered during the same time period.

8 (2) For example, if a recipient is receiving a speech-language pathology service from
9 a speech-language pathologist enrolled with the Medicaid Program, the department
10 shall not reimburse for the same service provided to the same recipient during the
11 same time period via the physicians' services program.

12 Section 10.~~[9.]~~ Third Party Liability. A provider shall comply with KRS 205.622.

13 Section 11.~~[40.]~~ Use of Electronic Signatures. (1) The creation, transmission, stor-
14 age, and other use of electronic signatures and documents shall comply with the re-
15 quirements established in KRS 369.101 to 369.120.

16 (2) A provider that chooses to use electronic signatures shall:

17 (a) Develop and implement a written security policy that shall:

18 1. Be adhered to by each of the provider's employees, officers, agents, or contrac-
19 tors;

20 2. Identify each electronic signature for which an individual has access; and

21 3. Ensure that each electronic signature is created, transmitted, and stored in a se-
22 cure fashion;

23 (b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;
2. Attest to the signature's authenticity; and
3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;
2. The signed consent form; and
3. The original filed signature.

Section 12.~~[14.]~~ Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with the claim or medical record.

Section 13.~~[12.]~~ Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 14.~~[13.]~~ Appeal Rights. An appeal of a department decision regarding:

(1) A Medicaid recipient who is not enrolled with a managed care organization based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563; or

(2) An enrollee based upon an application of this administrative regulation shall be in accordance with 907 KAR 17:010.

907 KAR 3:005

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

907 KAR 3:005

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on October 21, 2014 at 9:00 a.m. in Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing October 14, 2014, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until October 31, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 3:005

Contact Person: Stuart Owen (502) 564-4321, extension 2015

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid program coverage provisions and requirements regarding physician services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Medicaid program coverage provisions and requirements regarding physician services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid program coverage provisions and requirements regarding physician services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the Medicaid program coverage provisions and requirements regarding physician services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendments eliminate the option for a Medicaid-enrolled provider to provide Medicaid-covered services to a Medicaid recipient on the side (cash only basis apart from the Medicaid program) and clarify that the requirements established in DMS's independent behavioral health services administrative regulation (907 KAR 15:010) apply to such services provided by a physician, advanced practice registered nurse working for a physician, or a behavioral health practitioner under supervision working for a physician.

(b) The necessity of the amendment to this administrative regulation: The amendment regarding a non-Medicaid basis corrects an error that was overlooked in the internal review of the original administrative regulation. This non-Medicaid basis amendment is necessary to protect the health, safety, and welfare of Medicaid recipients as a provider who provides Medicaid-covered services to a Medicaid recipient apart from the Medicaid umbrella may circumvent the requirements (including safeguards to protect recipients) in providing the service. Additionally, a provider could exploit the non-Medicaid basis option if the provider wanted a payment higher than that paid by the Medicaid Program for a given service by informing the Medicaid recipient that the provider would only offer the service if the recipient paid in cash. Recipients would be vulnerable to such exploitation. For example, the "cash only" scenario has been used with suboxone and opioid dependence treatment for example. Suboxone is a drug used in tandem with opioid dependence treatment and some providers in Kentucky only offer the drug and treatment on a cash only (non-Medicaid/non-commercial insurer) basis and at a high price to individuals. An individual who is addicted to opioids is vulnerable to such exploitation. The amendment regarding the applicability of 907 KAR 15:010

(Coverage provisions and requirements regarding behavioral health services provided by independent providers) is necessary for clarity.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by enhancing the health, safety, and welfare of Medicaid recipients and by clarifying policies.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by enhancing the health, safety, and welfare of Medicaid recipients and by clarifying policies.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The administrative regulation affects physicians enrolled in the Medicaid program. Currently, there are over 14,000 individual physicians and over 1,700 physician group practices participating in the Medicaid Program. Medicaid recipients who receive services will be affected by the amendment.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Medicaid providers who provided Medicaid-covered services to Medicaid recipients will have to bill the Medicaid Program for such services and not bill the recipient.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No cost is imposed on providers.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): As a result of the amendment Medicaid recipients will benefit by not being potential victims of Medicaid providers who could use the non-Medicaid basis option to exploit them.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates no additional cost as a result of the amendment.

(b) On a continuing basis: DMS anticipates no additional cost as a result of the amendment.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The current fiscal year budget will not need to be adjusted to provide

funds for implementing this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or increase any fees.

(9) Tiering: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 907 KAR 3:005

Contact Person: Stuart Owen (502) 564-4321, extension 2015

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10) and 42 U.S.C. 1396a(a)(19).

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(10) mandates that a state's Medicaid Program cover physician services. 42 U.S.C. 1396a(a)(19) requires Medicaid programs to provide care and services consistent with the best interests of Medicaid recipients.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment does not impose stricter, additional or different requirements than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 907 KAR 3:005

Contact Person: Stuart Owen (502) 564-4321, extension 2015

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect all physicians enrolled in the Medicaid program who are not reimbursed via a managed care organization.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 42 C.F.R. 447.26 and this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment will not generate any additional revenue for state or local governments during the first year of implementation.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate any additional revenue for state or local governments during subsequent years of implementation.

(c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no additional cost as a result of the amendment.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation: No additional expenditures are necessary to implement this amendment.